14. Medicare Part B revenues;

A. Revenues received from Part B charges through Medicare intermediaries will be offset;

B. Seventy-five percent (75%) of the revenues received from Part B charges through Medicare carriers will be offset;

15. Personal services;

16. Activity income; and

17. Revenue recorded for donated services and commodities.

(B) Restricted funds designated by the donor prior to the donation for payment of operating costs will be offset from the associated cost.

(C) Restricted funds designated by the donor for capital expenditures will not be offset from allowable expenses.

(D) Unrestricted funds not designated by the provider for future capital expenditures will be offset from allowable cost.

(E) As applicable, restricted and unrestricted funds will be offset in each cost component, excluding capital, in an amount equal to the cost component's proportionate share of allowable expense.

(F) Any tax levies which are collected by nursing home districts or county homes that are supported in whole or in part by these levies, will not be offset.

(G) Gains on disposal of assets will not be offset from allowable expenses.

(10) Provider Reporting and Record Keeping Requirements.

(A) Annual Cost Report.

1. Each provider shall adopt the same twelve (12) month fiscal period for completing its cost report as is used for federal income tax reporting.

2. Each provider is required to complete and submit to the Division an annual cost report, including all worksheets, attachments, schedules and requests for additional information from the Division. The cost report shall be submitted on forms provided by the Division for that purpose. Any substitute or computer generated cost report must have prior approval by the Division.

3. All cost reports shall be completed in accordance with the requirements of this regulation and the cost report instructions. Financial reporting shall adhere to GAAP, except as otherwise specifically indicated in this regulation.

4. The cost report submitted must be based on the accrual basis of accounting. Governmental institutions operating on a cash or modified cash basis of accounting may continue to report on that basis, provided appropriate treatment for capital expenditures is made under GAAP.

5. Cost reports shall be submitted by the first day of the fourth month following the close of the fiscal period, unless an extension has been granted.

6. If requested in writing and postmarked prior to the first day of the fourth month following the close of the fiscal period, one (1) thirty (30) day extension of the filing date may be granted.

7. If a cost report is more than ten (10) days past due, payment shall be withheld from the facility until the cost report is submitted. Upon receipt of a cost report prepared in accordance with this regulation, the payments that were withheld will be released to the provider. For cost reports which are more than ninety (90) days past due, the Department may terminate the provider's Medicaid participation agreement and if terminated retain all payments which have been withheld pursuant to this provision.

8. Copies of signed agreements and other significant documents related to the provider's operation and provision of care to Medicaid recipients must be attached (unless otherwise noted) to the cost report at the time of filing unless current and accurate copies have already been filed with the Division. Material which must be submitted or available upon request includes, but is not limited to, the following:

A. Audit prepared by an independent accountant, including disclosure statements and management letter or SEC Form 10-K;

B. Contracts or agreements involving the purchase of facilities or equipment during the last seven (7) years if requested by the Division, the Department or its agents;

C. Contracts or agreements with owners or related parties;

D. Contracts with consultants;

E. Documentation of expenditures, by line item, made under all restricted and unrestricted grants;

F. Federal and state income tax returns for the fiscal year, if requested by the Division, the Department or its agents;

G. Leases and/or rental agreements related to the activities of the provider if requested by the Division, the Department or its agents;

H. Management contracts;

I. Medicare cost report, if applicable;

J. Review and compilation statement;

K. Statement verifying the restrictions as specified by the donor, prior to donation, for all restricted grants;

L. Working trial balance actually used to prepare the cost report with line number tracing notations or similar identifications; and

M. Schedule of capital assets with corresponding debt.

9. Cost reports must be fully, clearly and accurately completed. All required attachments must be submitted before a cost report is considered complete. If any additional information, documentation or clarification requested by the Division or its authorized agent is not provided within fourteen (14) days of the date of receipt of the Division's request, payments may be withheld from the facility until the information is submitted.

10. Under no circumstances will the Division accept amended cost reports for rate determination or rate adjustment after the date of the Division's notification of the final determination of the rate.

(B) Certification of Cost Reports.

1. The accuracy and validity of the cost report must be certified by the provider. Certification must be made by a person authorized by one (1) of the following: for an incorporated entity, an officer of the corporation; for a partnership, a partner; for a sole proprietorship or sole owner, the owner or licensed operator; or for a public facility, the chief administrative officer of the facility. Proof of such authorization shall be furnished upon request.

2. Cost reports must be notarized by a commissioned notary public.

3. The following statement must be signed on each cost report to certify its accuracy and validity:

Certification Statement: Misrepresentation or falsification of any information contained in this cost report may be punishable by fine and/or imprisonment under state or federal law.

I hereby certify that I have read the above statement and that I have examined the accompanying cost report and supporting schedules prepared by (provider name and number) for the cost report period beginning (date/year) and ending (date/year), and that to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted.

Signature	Title	Date

(C) Adequate Records and Documentation.

1. A provider must keep records in accordance with GAAP and maintain sufficient internal control and documentation to satisfy audit requirements and other requirements of this regulation, including reasonable requests by the Division or its authorized agent for additional information.

2. Each of a provider's funded accounts must be separately maintained with all account activity clearly identified.

3. Adequate documentation for all line items on the cost report shall be maintained by a provider. Upon request, all original documentation and records must be made available for review by the Division or its authorized agent at the same site at which the services were provided or at the central office/home office if located in the State of Missouri. Copies of documentation and records shall be submitted to the Division or its authorized agent upon request.

4. Each facility shall retain all financial information, data and records relating to the operation and reimbursement of the facility for a period of not less than seven (7) years.

(D) Audits.

1. Any cost report submitted may be subject to field audit by the Division or its authorized agent.

2. A provider shall have available at the field audit location one (1) or more knowledgeable persons authorized by the provider and capable of explaining the provider's accounting and control system and cost report preparation, including all attachments and allocations.

3. If a provider maintains any records or documentation at a location which is not the same as the site where services were provided, other than central offices/home offices not located in the State of Missouri, the provider shall transfer the records to the same facility at which the Medicaid services were provided, or the provider must reimburse the Division or its authorized agent for reasonable travel costs necessary to perform any part of the field audit in any off-site location, if the location is acceptable to the Division.

4. Those providers initially entering the program shall be required to have an annual independent audit of the financial records, used to prepare annual cost reports covering at a minimum the first two (2) full twelve (12) month fiscal years of their participation in the Medicaid Program, in accordance with GAAP and Generally Accepted Auditing Standards. The audit shall include, but may not be limited to, the Balance Sheet, Income Statement, Statement of Retained Earnings and Statement of Cash Flow. For example, a provider begins participation in the Medicaid Program in March and chooses a fiscal year of October 1 to September 30. The first cost report will cover March through September. That cost report may be audited at the option of the provider. The October 1 to September 30 cost report, the first full twelve (12) month fiscal year cost report, shall be audited. The next October 1 to September 30 cost report, the second full twelve (12) month cost report, shall be audited. The audits shall be done by an independent certified public accountant.

(E) Change in Provider Status.

1. If a provider notifies, in writing, the Director of the Institutional Reimbursement Unit of the Division prior to the change of control, ownership or termination of participation in the Medicaid Program, the Division will withhold all

remaining payments from the selling provider until the cost report is filed. The fully completed cost report with all required attachments and documentation is due the first day of the fourth month after the date of change of control, ownership or termination. Upon receipt of a cost report prepared in accordance with this regulation, any payment that was withheld will be released to the selling provider.

2. If the Director of the Institutional Reimbursement Unit does not receive, in writing, notification of a change of control or ownership and a cost report ending with the date of the change of control or ownership, upon learning of a change of control or ownership, $30,000 of the next available full month Medicaid payment, after learning of the change of control or ownership, will be withheld from the provider identified in the current Medicaid participation agreement until a cost report is filed. If the Medicaid payment is less than $30,000, the entire payment will be withheld. Once the cost report, prepared in accordance with this regulation, is received the payment will be released to the provider identified in the current Medicaid participation agreement.

(F) Joint Use of Resources.

1. If a provider has business enterprises in addition to the HIV nursing facility, the revenues, expenses, statistical and financial records of each separate enterprise shall be clearly identifiable.

2. When the facility is owned, controlled or managed by an entity or entities that own, control or manage one (1) or more other facilities, records of central office and other costs incurred outside the facility shall be maintained so as to separately identify revenues and expenses of, and allocations to, individual facilities. Direct allocation of cost,

such as RN consultant, which can be directly identifiable in the central office/home office cost and directly allocated to a facility by actual amounts or actual time spent. These direct costs shall be reported on the appropriate lines of the cost report. Allocation of central office/home office or management company costs to individual facilities should be consistent from year to year. If a desk audit or field audit establishes that records are not maintained so as to clearly identify information required by this regulation, those commingled costs shall not be recognized as allowable costs in determining the facility's Medicaid reimbursement rate. Allowability of these costs shall be determined in accordance with the provisions of this regulation.

(11) Cost Components and Per Diem Calculation. The Division will use the HIV nursing facility rate setting cost report.

(A) Patient Care. Each HIV nursing facility's patient care per diem shall be the lower of:

1. Allowable cost per patient day for patient care as determined by the Division from the rate setting cost report; or

2. The per diem ceiling of 120% of the patient care median determined by the Division from the databank.

(B) Ancillary. Each HIV nursing facility's ancillary per diem will be the lower of:

1. Allowable cost per patient day for ancillary as determined by the Division from the rate setting cost report; or

2. The per diem ceiling of 120% of the ancillary median determined by the Division from the databank.

(C) Administration. Each HIV nursing facility's administration per diem shall be the lower of:

1. Allowable cost per patient day for administration as determined by the Division from the rate setting cost report and adjusted for minimum utilization, if applicable, as described in Subsection (7)(O); or

2. The per diem ceiling of 110% of the administration median determined by the Division from the databank.

(D) Capital. Each HIV nursing facility's capital per diem shall be determined using the Fair Rental Value System as follows:

1. Rental Value.

A. Determine the total asset value.

(I) Determine facility size from the rate setting cost report;

(II) Determine the number of increased licensed beds after the rate setting cost report.

(III) Determine the bed equivalency for renovations/major improvements after November 30, 1995, by taking the cost of the renovations/major improvements divided by the asset value per bed for the year of the renovation/major improvement rounded to the nearest whole bed. The cost must be at least the asset value per bed for the year of the renovation/major improvement. For example, a renovations/major improvements cost of $200,000 is equal to 6 beds. ($200,000/ $32,723 equals 6.11 beds rounded to 6 beds);

(IV) Determine the number of decreased licensed beds after the rate setting cost report.

(V) Sum of (I),(II),(III) less (IV) times the asset value is the Total Asset Value.

B. Determine the reduction for age by multiplying the age of the beds by one percent (1%) up to forty percent (40%). For multiple licensing dates, the result of the weighted average age calculation will be limited to forty percent (40%).

(I) The age of the beds for multiple licensing dates is calculated on a weighted average method rounded to the nearest whole year. For example, a facility with original licensure in 1977 of 60 beds and an additional licensure of 60 beds in 1982 and 10 beds in 1993, the reduction is calculated as follows:

Licensure Year	Age	Beds	Age x Beds
1977	17	60	1,020
1982	12	60	720
1993	1	10	10
Total		130	1,750

Weighted Average Age - 1750/130 beds = 13.5 years rounded to 14 years. This results in a reduction for age of the beds of 14%.

(II) The age of the beds for replacement beds is calculated on a weighted average method rounded to the nearest whole year with the oldest beds always being replaced first. For example, a facility with 120 beds licensed in 1978 with replacement of 60 beds in 1988, the reduction is calculated as follows:

Licensure Year	Age	Beds	Age x Beds
1978	16	60	960
1988	6	60	360
Total		120	1,320

Weighted Average Age - 1320/120 = 11 years. This results in a reduction for age of the beds of 11%.

(III) The age of the beds for reductions in licensed beds is calculated on a weighted average method rounded to the nearest whole year with the oldest beds always being delicensed first. For example, a facility with original licensure in 1977 of 60 beds, additional licensure of 60 beds in 1982 and 10 beds in 1993 and a reduction of 10 beds in 1985, the reduction percentage is calculated as follows:

Licensure Year	Age	Beds	Age x Beds
1977	17	60	1020
1982	12	60	720
1993	1	10	10
1985*	17	(10)	(170)
Total		120	1580

* reduction of 1977 beds

Weighted Average Age - 1580/120 beds = 13.2 years rounded to 13 years. This results in a reduction for age of the beds of 13%.

(IV) The age of the beds equivalents for renovations/major improvements is calculated on a weighted average method rounded to the nearest whole year. For example, a 120 bed facility licensed in 1978 undertakes two renovations: $200,000 in 1983 and $100,000 in 1993. The asset value per bed is $32,723. The bed equivalency is 6 beds for 1983 and 3 beds for 1993, the reduction percentage is calculated as follows:

Licensure/ Construction Year	Age	Beds	Age x Beds
1978	16	120	1,920
1983	11	6	66
1993	1	3	3
Total		129	1,989

Weighted Average Method - 1989/129 = 15.42 years rounded to 15 years. This results in a reduction for age of beds of 15%.

C. The facility asset value is subparagraph (11)(D)1.A. less subparagraph (11)(D)1.B.

D. Multiply the facility asset value by two and one-half percent (2.5%) to determine the rental value. The two and one-half (2.5%) is based on a forty (40) year life.

E. The following is an illustration of how subparagraphs (11)(D)1.A., (11)(D)1.B. and (11)(D)1.C., (11)(D)1.D. determines the rental value:

(I) Total Facility Size - 174 beds
Weighted Avg Age of the Beds - 23 yrs
Capital Asset Debt - $2,371,094
Asset Value - $32,723

(II) The Total Asset Value is the product of the Total Facility Size times the Asset Value;

Total Facility Size	174
Asset Value	x $32,723
Total Asset Value	$5,693,802

(III) Facility Asset Value is Total Asset Value less the Reduction for Age of the Beds; and

Reduction for Age (23%)	$1,309,574
Facility Asset Value	
$4,384,228	

(IV) Rental Value is the Facility Asset Value multiplied by 2.5%.

	X 2.5%
Rental Value	$ 109,606

2. Rate of Return.

A. Reduce the Facility Asset Value by the Capital Asset Debt, but not less than zero, times the percentage of return. The percentage of return is the yield for the thirty (30) year Treasury Bond as reported by the Federal Reserve Board and published in the *Wall Street Journal* for the week ending June 30, 1995, plus two percentage (2%) points. The rate is 6.58% for the week ending June 30, 1995, plus 2% for a total of 8.58%.

B. The debt associated with increases in licensed beds or renovations/major improvements after the end of the facility's rate setting cost report and will be added to the capital asset debt from the rate setting cost report. The facility shall provide adequate documentation to support the additional debt as required in paragraph (7)(E)2. If adequate documentation is not provided to support the additional asset debt, it will be assumed to equal the facility asset value.

C. The following is an illustration of how subparagraph (11)(D)2.A. is calculated:

Facility Asset Value	$4,331,573
Capital Asset Debt	$2,371,094
	$1,960,479
Percentage of Return	X 9.48%
Rate of Return	$ 185,853

3. Computed Interest and Pass Through Expenses.

A. Add property insurance (line 107) and property taxes (lines 108 and 109). Also add interest subject to limits identified in subsection (7)(F). These lines are found in the cost report, version MSIR-1 (3-95).

B. The following is an illustration of how subparagraphs (11)(D)3.A. is calculated:

Computed Interest	$ 207,840
Insurance	$ 7,594
Property Taxes	$ 40,548
Pass Through Expenses	$ 48,142

4. Capital Component Per Diem Calculation.

A. A per diem is calculated by dividing the sum of rental value, rate of return and computed interest by the number of beds determined in subparagraph (11)(D)1.A. times 365 adjusted by the greater of the minimum utilization as determined in subsection (7)(O) or the facility's occupancy from the rate setting cost report. The following is an illustration of how subparagraph (11)(D)4.A. is calculated:

Rental Value	$ 108,289
Rate of Return	$ 185,853
Computed Interest	$ 207,840
Total	$ 501,982
Divided by Annualized Patient Days	56,077
Capital Per Diem	$ 8.95

B. A per diem is calculated by dividing the pass through expenses by the greater of the minimum utilization as determined in subsection (7)(O) or the facility's patient days from the rate setting cost report. The following is an illustration of how subparagraph (11)(D)4.B. is calculated:

Pass Through Expenses	$ 48,142
Patient Days	55,146
Pass Through Per Diem	$ .87

C. The capital component per diem is the sum of subparagraph (11)(D)4.A. and (11)(D)4.B.

Capital Per Diem	$8.95
Pass Through Per Diem	$ .87
Total Capital Component Per Diem	$9.82

(E) Working Capital Allowance. Each HIV nursing facility's working capital per diem shall be equal to one and one-tenth (1.1) months of each facility's per diem for patient care, ancillary and administration times the Chase Manhattan prime rate on July 3, 1995, plus two percentage (2%) points. The following is an illustration of how subsection (11)(E) is calculated:

Patient Care	$ 30.00
Ancillary	$ 7.00
Administration	$ 20.00
Total Per Diem	$ 57.00
divided by 12 months	12
	$ 4.75
Times 1.1 months	1.1
	$ 5.23
Times Prime + 2% (Chase Manhattan + 2%)	11%
Working Capital Allowance per day	$ .58

(F) The following is an illustration of how subsections (11)(A), (11)(B), (11)(C), (11)(D) and (11)(E) determine the per diem rate:

	Allowable	Cost Ceiling	Per Diem
Patient Care	$38.00	$40.00	$38.00
Ancillary	$ 8.00	$ 6.00	$ 6.00
Administration	$12.00	$11.00	$11.00
Capital (FRV)			$ 9.82
Working Capital Allowance			$ .58
Total Per Diem			$65.40

(12) Reimbursement Rate Determination. A HIV nursing facility's reimbursement rate shall be determined by the Division as described in sections (11), (12), (13) and (14), subject to limitations prescribed elsewhere in this regulation.

(A) A facility entering the Medicaid Program after November 30, 1995, shall receive an interim rate as defined in subsection (4)(FF) to be effective on the initial date of Medicaid certification. A prospective rate shall be determined in accordance with section (11) from the desk audited and/or field audited facility fiscal year cost report which covers the second full twelve (12) month fiscal year following the facility's initial date of Medicaid certification. This prospective rate shall be retroactively effective and shall replace the interim rate for services beginning on the first day of the facility's second full twelve (12) month fiscal year.

(B) A facility with a valid Medicaid participation agreement in effect after November 30, 1995, which either voluntarily or involuntarily terminates its participation in the Medicaid Program and which re-enters the Medicaid Program, shall have its prospective rate established as the rate in effect on the day prior to the date of termination from participation in the program plus rate adjustments which may have been granted with effective dates subsequent to the termination date but prior to re-entry into the program as described in subsection (13)(A). This prospective rate shall be effective for service dates on and after the effective date of the re-entry following a voluntary or involuntary termination.

(13) Adjustments to the Reimbursement Rates. Subject to the limitations prescribed elsewhere in this regulation, a facility's reimbursement rate may be adjusted as described in this section.

(A) Global per diem rate adjustments. A facility with either an interim rate or a prospective rate may qualify for the global per diem rate adjustments. Global per diem rate adjustments shall be added to the specified cost component ceiling.

(B) Special per diem rate adjustments. Special per diem rate adjustment may be added to a qualifying HIV nursing facility's rate without regard to the cost component ceiling if specifically provided as described below.

1. Replacement Beds. A facility with a prospective rate in effect after November 30, 1995, may request a rate adjustment for replacement beds that resulted in the same number of beds being delicensed with the Division of Aging. The facility shall provide documentation from the Division of Aging that verifies the number of beds used for replacement have been delicensed from that facility. The rate adjustment will be calculated as the difference between the capital component per diem (Fair Rental Value, FRV) prior to the replacement beds being placed in service and the capital component per diem (Fair Rental Value, FRV) including the replacement beds placed in service as calculated in subsection (11)(D) including the replacement beds placed in service. The capital component is calculated for the replacement beds using the asset value per licensed bed as determined using the R. S. Means Construction Index for nursing facility beds adjusted for the Missouri indexes for the date the replacement beds are placed in service.

2. Additional Beds. A facility with a prospective rate in effect after November 30, 1995, may request a rate adjustment for additional beds. The facility must obtain an approved certificate of need or applicable waiver for the additional beds. The rate adjustment will be calculated as the difference between the capital component per diem (Fair Rental Value, FRV) prior to the additional beds being placed in service and the capital component per diem (Fair Rental Value, FRV) including the additional beds as calculated in subsection (11)(D) including the additional beds placed in service. The capital component is

calculated for the additional beds using the asset value per licensed bed as determined using the R. S. Means Construction Index for nursing facility beds adjusted for the Missouri indexes for the date the additional beds are placed in service.

3. Extraordinary Circumstances. A participating facility which has a prospective rate may request an adjustment to its prospective rate due to extraordinary circumstances. This request must be submitted in writing to the Division within one (1) year of the occurrence of the extraordinary circumstance. The request must clearly and specifically identify the conditions for which the rate adjustment is sought. The dollar amount of the requested rate adjustment must be supported by complete, accurate and documented records satisfactory to the Division. If the Division makes a written request for additional information and the facility does not comply within ninety (90) days of the request for additional information, the Division shall consider the request withdrawn. Requests for rate adjustments that have been withdrawn by the facility or are considered withdrawn because of failure to supply requested information may be resubmitted once for the requested rate adjustment. In the case of a rate adjustment request that has been withdrawn and then resubmitted, the effective date shall be the first day of the month in which the resubmitted request was made providing that it was made prior to the tenth day of the month. If the resubmitted request is not filed by the tenth of the month, rate adjustments shall be effective the first day of the following month. Conditions for an extraordinary circumstance are as follows:

A. When the provider can show that it incurred higher costs due to circumstances beyond its control, the circumstances were not experienced by the nursing home industry in general and the costs have a substantial cost effect.

B. Extraordinary circumstances include:

(I) Natural disasters such as fire, earthquakes and flood that are not covered by insurance and that occur in a federally declared disaster area; and

(II) Vandalism and/or civil disorder that are not covered by insurance.

C. The rate increase shall be calculated as follows:

(I) The one (1) time costs, (costs that will not be incurred in future fiscal years):

(a) To determine what portion of the incurred costs will be paid, the Division will use the patient occupancy days from latest available quarterly occupancy survey from the Division of Aging for the time period preceding when the extraordinary circumstances occurred; and

(b) The costs directly associated with the extraordinary circumstances will be multiplied by the above percent. This amount will be divided by the paid days for the month the rate adjustment becomes effective per paragraph (13)(B)3. This calculation will equal the amount to be added to the prospective rate for only one (1) month, which will be the month the rate adjustment becomes effective. For this one (1) month only, the ceiling will be waived.

(II) For on going costs (costs that will be incurred in future fiscal years): On going annual costs will be divided by the greater of: annualized (calculated for a twelve (12) month period) total patient days from the latest cost report on file or eighty-five percent (85%) of annualized total bed days. This calculation will equal the amount to be added to the respective cost center, not to exceed the cost component ceiling. The rate adjustment, subject to ceiling limits will be added to the prospective rate.

(III) For capitalized costs, a capital component per diem (Fair Rental Value, FRV) will be calculated as determined in subsection (11)(D). The rate adjustment will be calculated as the difference between the capital component per diem (Fair Rental Value, FRV) prior to the extraordinary circumstances and the capital component per diem (Fair Rental Value, FRV) including the extraordinary circumstances.

(C) Conditions for prospective rate adjustments. The Division may adjust a facility's prospective rate both retrospectively and prospectively under the following conditions:

1. Fraud, misrepresentation, errors. When information contained in a facility's cost report is found to be fraudulent, misrepresented or inaccurate, the facility's prospective rate may be both retroactively and prospectively reduced if the fraudulent, misrepresented or inaccurate information as originally reported resulted in establishment of a higher, prospective rate than the facility would have received in the absence of such information. No decision by the Division to impose a rate adjustment in the case of fraudulent, misrepresented or inaccurate information shall in any way affect the Division's ability to impose any sanctions authorized by statute or regulation.

The fact that fraudulent, misrepresented or inaccurate information reported did not result in establishment of a higher prospective rate than the facility would have received in the absence of this information also does not affect the Division's ability to impose any sanctions authorized by statute or regulation;

2. Decisions of the Administrative Hearing Commission, or settlement agreements approved by the Administrative Hearing Commission;

3. Court Order; and

4. Disallowance of federal financial participation.

(14) Exceptions.

(A) For those Medicaid-eligible recipients who have concurrent Medicare Part A skilled nursing facility benefits available, Medicaid reimbursement for covered days of stay in a qualified facility will be based on this coinsurance as may be imposed under Title XVIII.

(15) Sanctions and Overpayments.

(A) In addition to the sanctions and penalties set forth in this regulation, the Division may also impose sanctions against a provider in accordance with state regulation 13 CSR 70-3.030, Sanctions for False or Fraudulent Claims for Title XIX Services, or any other sanction authorized by state or federal law or regulations.

(B) Overpayments due the Medicaid Program from a provider shall be recovered by the Division in accordance with state regulation 13 CSR 70-3.030, Sanctions for False or Fraudulent Claims for Title XIX Services.

(16) Appeals. In accordance with sections 208.156, RSMo 1986, and 622.055, RSMo (Supp. 1989), providers may seek hearing before the Administrative Hearing Commission of final decisions of the Director or the Division.

(17) Payment in Full. Participation in the program shall be limited to providers who accept as payment in full, for covered services rendered to Medicaid recipients, the amount paid in accordance with these regulations and other applicable payments.

(18) Provider Participation. Payments made in accordance with the standards and methods described in this regulation are designed to enlist participation of a sufficient number of providers in the program so that eligible persons can receive the medical care and services included in the regulation at least to the extent these services are available to the general public.

(19) Transition. Cost reports used for rate determination shall be adjusted by the Division in accordance with the applicable cost principles provided in this regulation.